HIV/AIDS STRATEGY, 2002-2005

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Contents

ACRONYMS

AFEW	AIDS Foundation East-West (formerly MSF/Holland)
AIDS	acquired immune deficiency syndrome
AVSC	Association for Voluntary and Safe Contraception
BCC	behavior change communication
BSS	behavior surveilla□ce survey
BU	Boston University
CDC	Centers for Disease Control and Prevention
CIDA	Canadian International Development Agency
CIU	Center for International Understanding
CTO	Cognizant Technical Officer
DFID	Department for International Development
FHI	Family Health International
HIV	human immunodeficiency virus
HTA	high transmission area
IDU	injecting drug user
IEC	information, education and communication
IR	intermediate result
ISVD	Central Institute for Skin and Venereal Diseases
LESHRC	Lower East Side Harm Reduction Center
MOH	Ministry of Health
MSF	Medecins Sans Frontieres
MSH	Management Sciences for Health
MSM	males who have sex with males
NAN	No to Alcoholism and Drug Addiction
NGO	non-governmental organization
OSI	Open Society Institute
PASA	Participating Agency Support Agreement
PLACE	Priorities for Local AIDS Control Efforts
PLWA	people living with AIDS
PSI	Population Services International
RF	Russian Federation
RLMS	Russian Longitudinal Monitoring Survey
SANAM	Russian Association Against Sexually Transmitted Diseases
STD	sexually transmitted disease
STI	sexually transmitted infection
SW	sex worker
TA	technical assistance
UN	United Nations
UNC	University of North Carolina
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	voluntary counseling and testing
WHO	World Health Organization
WWC	Whitman Walker Clinic

ABSTRACT

Current models suggest that HIV prevalence in Russia will increase from 0.7% to roughly 4-5% between 2002 and 2005. Multiple, focal epidemics are now occurring throughout the country in such marginalized populations as drug users, sex workers and men who have sex with men. Although community-based, representative, HIV prevalence data for these populations are very limited, what data are available describe extremely high rates of infection. Studies from Togliatti City (Samara Oblast), Kaliningrad, Moscow, and elsewhere have found between one-third and one-half of those surveyed to be infected. In the last decade, Russia has seen an explosive syphilis epidemic, and sharply increased rates of gonorrhea. A general trend towards earlier sexual debut and low rates of condom use among Russian youth raise serious concerns about the future direction of the epidemic.

Several factors have hindered an effective response to the epidemic. To date, HIV/AIDS prevention programs have had low rates of coverage of the highest risk populations; behavior change communication campaigns have promoted generally diffuse messages; inadequate attention has been paid to STIs; and institutional, policy and operational barriers to care and treatment have been insufficiently addressed.

By directly engaging PLWHA and individuals from vulnerable and marginalized communities, and by designing prevention and care efforts with them to address their needs, the USAID/Russia 2002-2005 HIV/AIDS Strategy will achieve a reduction in the escalating rate of HIV infection and will reduce the projected impact of the epidemic upon the Russian economy and society. The Strategy anticipates three main results to support this objective:

1. Improved HIV/AIDS service delivery (BCC, VCT, STI) interventions
2. Improved use of epidemiological data for programming and policy development.
3. Improved replication, adoption and use of lessons learned.

The strategy continues USAID/Russia's previous emphasis on youth, on the development of increased local capacity to respond to the epidemic, and on stregthening programs in three geographical areas: Moscow city, Saratov oblast and Samara oblast. Additionally, NGO partnerships and networks will be supported to extend efforts in these areas, and into areas of emerging epidemics, for example in the Russian Far East and Siberia. USAID/Russia's 2002-2005 Strategy will work effectively in collaboration with the Russian Government, the international donor community, and local NGOs and leaders.

EXECUTIVE SUMMARY [RUSSIAN VERSION]

Current Status of the HIV Epidemic in Russia

The rate of increase of HIV prevalence in Russia is truly staggering, with current estimates suggesting that adult HIV prevalence in the country will increase from 0.7% to roughly 4-5% between 2002 and 2005, the time period for which this strategy is proposed. Multiple, focal epidemics are now occurring in marginalized populations throughout the country. Although community-based, representative, HIV prevalence data for these populations is very limited in Russia, what data is available describes extremely high rates of infection among these population groups. For example, in a 2001 study in Togliatti City, Samara Oblast, over one-half of injecting drug users surveyed were found to be HIV positive. Studies of sex workers in Kaliningrad and Moscow, starting as early as five years ago, have found up to one-third of those surveyed infected. The impact of the epidemic on gross domestic product can be estimated at greater than one percent annually by the year 2005, and will grow even higher as individuals with HIV infection develop AIDS.

Several factors fuel the on-going transmission of HIV in marginalized and vulnerable communities:

- STI's are known to increase the transmission of HIV. An explosive syphilis epidemic began in 1992-3, and infected individuals continue to suffer poor access to health care and poor standards of care.
- Urban centers have large populations injecting drugs and engaging in commercial sex (or sex for survival) with low levels of condom use and high levels of needle/syringe sharing.
- Men who have sex with men are stigmatized and discriminated against, and report high levels of risky drug and sexual behaviors.

Although the HIV/AIDS epidemic will likely shift to reflect more diverse means of transmission (that is, away from the dominance of injecting drug use) over the next three years, it will continue to disproportionately impact marginalized and vulnerable populations. Directly engaging these communities, and designing prevention and care efforts with them to address their needs, will remain for some time in the future the most effective means of reducing the potential impact of HIV in Russia.

Response to the Epidemic

Both the Russian government and the international donor community have increased their response to the epidemic, with the Russian Government showing increasing readiness to confront the country's HIV/AIDS crisis through prevention efforts and collaboration with the NGO sector. International donors have increased their support for HIV/AIDS programming, and have designed diverse strategies to reach marginalized and general populations and strengthen local capacity through both Russian government and NGO partners.

Despite increasingly vigorous efforts by the Russian Government, NGOs and various donors, a comprehensive response to the epidemic is still being constrained by a number of factors. The successes and lessons learned from HIV/AIDS prevention programming to date, for example, have been counter-balanced by the small scale and low level of coverage of at-risk populations. Inadequate donor resources restrict their interventions to modest 'pilot' efforts or 'model' programs designed in the hope that they can leverage Russian government health resources and infrastructure to replicate and scale up the smaller programs. Some specific limiting factors:

- *Harm reduction continues to play a primary role, but coverage is inadequate*. By 2001, 48 needle and syringe exchange programs (NSEPs) were operating across Russia. Most of these programs have been operating for less than two years; are generally located in urban areas; and reach a relatively small proportion of intravenous drug users (IDUs).

- *Few HIV prevention programs work with sexually transmitted infection (STI) clinics* to ensure that IDUs with STIs receive prompt treatment and that transmission of STIs and sexual transmission of HIV is addressed

- *Targeted interventions with sex workers and males having sex with males (MSM) have been extremely limited.* Among the few examples of such programs are USAID-supported campaigns by PSI in Saratov, SANAM/CDC in Moscow, and the NGO Partnership program in various locations. AIDS Infoshare implements a program in Moscow oblast

- *Youth and general population efforts have provided largely diffuse messages.* IEC campaigns are important to reduce stigma and to support more targeted interventions, but they have only limited effectiveness in promoting behavior change among the general population. Information disseminated through general mass media is likely to miss those individuals who are most at risk, and is unable to provide the type of information they need, e.g., to change individual risk perception or improve condom negotiating skills.

- *STI treatment protocols have been improved, but implementation is uncertain and accessibility by marginalized populations is poor.* CDC and WHO have worked constructively with SANAM and the Ministry of Health to strengthen STI treatment protocols. Effective implementation is spotty, however, depending on the resources and commitment in various regions.

- *Institutional and policy obstacles continue to prevent the expansion of effective STI/STD care to marginalized populations.* Barriers include e.g., Moscow residency permits (absent which public sector facilities often refuse treatment for high-risk adults and adolescents); limitations on NGOs ability to deliver services; lack of privacy; partner notification regulations; and high costs in the commercial private sector.

USAID/Russia 2002-2005 HIV/AIDS Strategy

As noted above, the Russian HIV/AIDS epidemic can be characterized by low current prevalence but explosive growth, concentrated among sexual and drug using networks in specific regions across Russia. An effective response has been constrained, however, by existing programs' low coverage of at-risk populations; generally diffuse information and behavior change campaigns of limited relevance to at-risk groups; inadequate attention to the exacerbating role of STIs; and institutional, policy and operational barriers to care and treatment, especially for vulnerable and marginalized populations. USAID/Russia's 2002-2005 HIV/AIDS Strategy is designed to address these factors by:

- Implementing focused, effective behavior change communication (BCC) programs targeting individuals at high risk of HIV infection.
- Increasing the availability and use of epidemiological data for effective HIV/AIDS programming and policy development.
- Building strong networks of public and private sector organizations capable of expanding the coverage of effective programs.
- Expanding access to quality STI services for marginalized populations; and
- Improving the provision of counseling in VCT settings.

The strategy continues the previous emphasis of USAID/Russia on youth, on the development of increased local capacity to respond to the epidemic, and on program in three geographical areas: Moscow, Saratov oblast and Samara oblast. Additionally, model programs and lessons learned will be shared through partnerships and small grants to NGOs in these areas and in areas of emerging epidemics, for example in the Russian Far East and Siberia.

The emphasis on these strategies will lead to three, anticipated, key results:

- Improved HIV/AIDS service delivery to reduce transmission
- Improved use of epidemiological data for programming and policy development.
- Improved replication, adoption and use of lessons learned.

The development of improved HIV/AIDS service delivery interventions in Russia will focus upon three types of programs: behavior change communication, STI care, and VCT. In Russia, IDUs, SWs and MSMs continue to be marginalized by official Russian policies and by stigma, discrimination, and the economic forces that have disrupted Russian society over the past decade. Individuals in these groups are most affected by the epidemic, and are most likely to spread the epidemic into broader populations and as-yet uninfected communities, but face enormous barriers to prevention information, services, and appropriate care and treatment. Working with populations with high levels of risk behaviors during the early stage of HIV epidemics is the only proven means of averting more widespread transmission of HIV, and provides the most cost-effective strategy for addressing the current stage of the Russian epidemic.

As part of improving service delivery to these populations, USAID/Russia proposes several activities, including efforts to:

- Improve the capacity of local government and NGO counterparts to design and implement BCC activities.
- Encourage greater partnership of Russian NGOs and Russian government counterparts in media and outreach activities
- Intensify cooperation with NGOs in Saratov Oblast to expand outreach and increase peer education activities among high-risk groups.
- Develop BCC messages that promote the prevention and treatment of STIs
- Expand peer education programs to reach high-risk groups and to refer clients to STI treatment centers.
- Provide technical assistance to improve the STI treatment capability of selected NGOs which already offer reproductive health services to marginalized populations
- Promote a policy dialogue with federal and regional governments to identify and remove regulatory and procedural barriers which impede the access of vulnerable groups to STI services.
- Expand quality VCT services in three oblasts (Moscow, Saratov and Samara)
- Develop outreach links and referral services to improve access to VCT for at-risk youth.

The second key result involves improving the use of epidemiological data. Currently, little data are available, and few programmatic or policy decisions are made using data to ensure that the most effective and efficient approach is taken. Better understanding the characteristics of vulnerable populations, and the high-risk environments in which program implementers can effectively reach them, is essential for insuring an impact upon the epidemic in a cost-effective way.

In order to achieve this result, USAID/Russia will support the expansion of essential, management-useful data for decision/policy makers, an increase in the capacity of local researchers to design, analyze and interpret epidemiological data, and the application of research results. Specific efforts to achieve this key result will include:

- Support for the expansion of formative data collection on high-risk populations through mapping and qualitative research.
- Support for quantitative monitoring of risk behaviors among IDU and FSW populations (BSS), and among the Russian general population (Russian Longitudinal Monitoring survey).
- Technical support to the Federal AIDS Center in behavioral research methods.
- Improved sharing of data with stakeholders and representatives of targeted communities and people living with AIDS (PLWA).
- Improve advocacy by incorporating sophisticated, yet simple and powerful, presentations of HIV/AIDS information to key policymakers at regional and national levels.

The third key result emphasizes building the capacity of individuals and organizations to respond more effectively to the HIV/AIDS epidemic, and to expand prevention and care activities to regions with emerging epidemics or little donor support. This initiative will develop and strengthen learning networks of diverse organizations (governmental and civil society) working at one site, and build collaboration across regions through the sharing of lessons learned between organization in USAID/Russia's 'core' regions of support and in new areas strategic to the future of the epidemic. Specific initiatives to achieve this result will include:

- Support for Russia-to-Russia NGO partnerships that replicate innovative but tested ways to reach vulnerable youth
- Support for joint NGO-Russian government approaches to HIV/AIDS outreach and service programs.
- Policy dialogue with the Russian Federation toward the removal of legal, regulatory and procedural barriers that limit the ability of NGOs to provide STI and VCT services.

Geographic Focus of the Strategy:

In general, program activities will be focused in Moscow city, Saratov oblast and Samara oblast. Specific high transmission areas will be identified within these areas in order to more narrowly, and realistically, define the districts (in the case of Moscow) or cities (in the case of Saratov and Samara) where activities will be concentrated. Some activities, such as media campaigns, will have more widespread coverage.

An important aspect of the strategy is the development of NGO partnerships between NGOs in areas supported by USAID/Russia and in areas outside of the 'core' area of support. The objective of these partnerships will be for the development of increased capacity in regions facing emerging epidemics, or lacking donor funding. These regions will likely include the Far East, border regions with high rates of commercial sex activity, and areas of recently introduced HIV into IDU populations. This aspect of the strategy will also allow for the sharing of lessons learned between organizations in the region of St. Petersburg and Kaliningrad (funded through the Baltic Sea Initiative), those funded under the REACH project (Siberia AIDS AID Tomsk Regional Charity Fund) and other initiatives (for example, the American Red Cross supported project in Irkutsk).

These networks will allow USAID/Russia to establish relationships with organizations throughout Russia, and to assess the state of the epidemic, and the capacity of local organizations that might benefit from increased funding, should additional resources become available. Additionally, depending on the availability of resources, USAID is prepared to explore opportunities for the development of cooperative programs with other donors in different parts of the country, particularly for the support of integrated interventions that might complement more narrowly focused harm reduction programs of other donors.

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Within the broad framework of USAID/Russia'a approved Strategic Objective to **"Increase the Use of Improved Health and Child Welfare Practices"**, this HIV/AIDS strategy will lead to the achievement of three Intermediate Results:

- IR 1: Improved HIV/AIDS service delivery to reduce transmission
- IR 2: Improved use of epidemiological data for programming and policy development
- IR 3: Improved replication, adoption and use of lessons learned.

IR 1 activities will focus upon three types of programs: behavior change communication, STI care, and VCT. In Russia, IDUs, SWs and MSMs continue to be marginalized by official Russian policies and by stigma, discrimination, and the economic forces that have disrupted Russian society over the past decade. Individuals in these groups are most affected by the epidemic, and are most likely to spread the epidemic into broader populations and as-yet uninfected communities, but face enormous barriers to prevention information, services, and appropriate care and treatment. Working with populations with high levels of risk behaviors during the early stage of HIV epidemics is the only proven

means of averting more widespread transmission of HIV, and provides the most cost-effective strategy for addressing the current stage of the Russian epidemic.

Illustrative activities which will contribute to the achievement of IR 1 will include efforts to:

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- Expand quality VCT services in three oblasts (Moscow, Saratov and Samara)
- Develop outreach links and referral services to improve access to VCT for at-risk youth.

IR 2 will focus on efforts to improve the use of epidemiological data. Currently, little data are available, and few programmatic or policy decisions are made using data to ensure that the most effective and efficient approach is taken. Better understanding the characteristics of vulnerable populations, and the high-risk environments in which program implementers can effectively reach them, is essential for insuring an impact upon the epidemic in a cost-effective way.

In order to achieve this result, USAID/Russia will support the expansion of essential, management-useful data for decision/policy makers, an increase in the capacity of local researchers to design, analyze and interpret epidemiological data, and the application of research results. Specific efforts to achieve this key result will include:

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IR 3 emphasizes building the capacity of individuals and organizations to respond more effectively to the HIV/AIDS epidemic, and to expand prevention and care activities to regions with emerging epidemics or little donor support. This initiative will develop and strengthen learning networks of diverse organizations (governmental and civil society) working at one site, and build collaboration across regions through the sharing of lessons learned between organization in USAID/Russia's 'core' regions of support and in new areas strategic to the future of the epidemic. Specific initiatives to achieve this result will include:

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interventions that might complement more narrowly focused harm reduction programs of other donors.

Monitoring and Evaluation Plan

The strategy includes an M&E plan designed to address the three reporting requirements of Intensive Focus Countries under USAID's Expanded Response Initiative. First is the requirement that USAID/Russia report yearly the HIV seroprevalence levels for Russia. The second requirement for Intensive Focus countries is that they conduct a behavior change survey every 3-5 years. Third, Intensive Focus countries are required to report on indicators specific to the HIV strategies and programs that they manage. These requirements correspond with standard, recommended guidelines for comprehensive program evaluation - in short, measuring program impact, outcome, and output.

Main Report

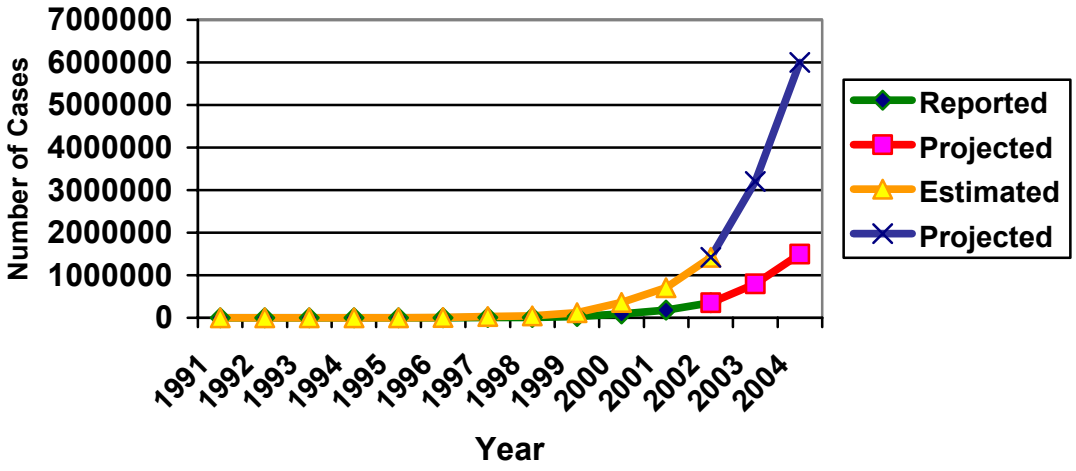
BACKGROUND

History and Current Status of the HIV epidemic in Russia

HIV prevalence

The rate of increase in HIV prevalence in Russia is truly staggering. The number of officially reported new cases of HIV infection has more than doubled each year (on average) between 1991 and 2001. The annual number of new cases increased from just under 20,000 reported new cases in 1999, to just under 60,000 in 2000, to over 87,000 new cases in 2001[1]. As with most reporting systems, these figures likely represent underestimates of the true situation, and estimated real numbers of new HIV infections are believed to be three to five fold greater. Using an epidemic model developed by the World Bank[2], updated for the number of reported cases through 2001, new HIV infections can be projected at over 270,000 reported cases in 2003 and 750,000 cases in 2004. Adjusting for underreporting puts the number of projected new cases at over 1 million by 2003 and 3 million by 2004 (see Figure 1, below). This projected rate of growth would result in an increase in overall HIV prevalence from 0.7% in 2002 to greater than 3% by 2004.

Figure 1: Cumulative and projected numbers of HIV in Russia



Sources: Reported figures are from the Russian Federal AIDS Center through 2001. Estimated figures represent consensus estimates (UNAIDS, Federal AIDS Center, DfID, others) of 4-fold under-reporting of registered cases. Projected figures are adjusted from March 2001 World Bank modeling based upon the number of reported cases and 4-fold underestimates.

While the above information provides an overall perspective on the epidemic, it masks the true nature and dynamics underlying the on-going spread of HIV in Russia, which is characterized by multiple, local epidemics occurring in marginalized populations throughout the country. Significant, advanced epidemics are underway in St. Petersburg, Moscow, Samara, Sverdlovsk, Irkutsk, and Khanti-Mansiiskii.

The percentage of reported HIV infections due to different transmission means (sexual, IDU, parental, etc.) has shifted over time as HIV has been introduced into homosexual, IDU, and heterosexual networks. In 1997, between 74% and 90% of new infections were among IDUs[3]. The 2002 report of the Federal AIDS Center states that 90% of reported HIV cases were due to IDU; however, for 43% of all new HIV cases no information on transmission risk was available. It is probably best to consider this figure as a wide range, with some regions reporting epidemics almost exclusively among IDUs and other regions reporting both IDU and sexual transmission. The Federal AIDS Center also reports a 3:1 ratio of men: women infected, with fifteen to twenty year olds representing about 25% of cases, and twenty to thirty year olds representing 60%.

Representative HIV prevalence data for marginalized populations are very limited in Russia, however what data is available describes high rates of infection. For example, in a 2001 study in Togliatti City, Samara Oblast, 56% of injecting drug users (IDU) surveyed were found to be HIV positive[4]. A 1997 study of street-based female sex workers in Kaliningrad found 32% HIV prevalence (and 30% injecting drug use)[5]. A 1999 survey of male and female sex workers in Moscow conducted by the Russian AIDS Center found an HIV prevalence of 14%.[6]

STI Prevalence

Russia has reported an equally explosive increase in STI infections. Since 1991, infection rates of syphilis increased more than 300-fold. Substantial increases in gonorrhea have also been reported. There is some evidence that the incidence of these two infections has leveled-off or may possibly be declining (see Figure 2 and 3), although declines may be due to reduced rates of active case finding and increased use of the private/informal sector for health care[7].

Figure 2: Reported Incidence of Newly Diagnosed Cases of Syphilis per 100,000

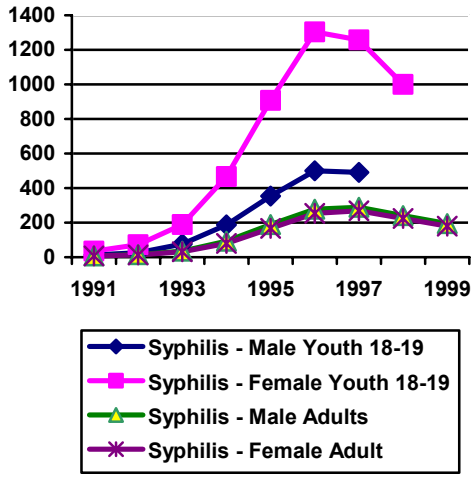
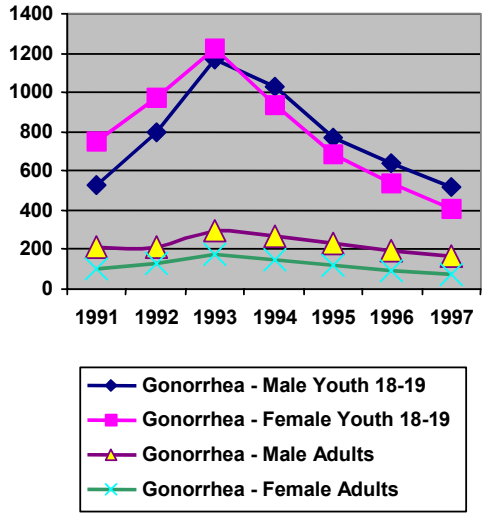


Figure 3: Reported Incidence of Newly Diagnosed Cases of Gonorrhea per 100,000 1991-1997



Nonetheless, syphilis rates remain 200-500 fold greater than in other developed countries, and because of its potential to increase HIV transmission efficiency, remain of significant concern. In addition, high rates of STI infection are still common in specific marginalized populations; for example, 12% of female youth in juvenile detention centers and 51% of women in homeless detention centers were found to have syphilis[8]. One-third of IDUs in St. Petersburg were found to have an untreated STI[9].

Contextual factors impacting the HIV epidemic

To understand comprehensively the characteristics of the HIV epidemic in Russia - in short, why and how the HIV epidemic has emerged, and what fuels its escalating rate - several contextual factors must be considered, including injecting drug use and risk behaviors among sex workers, MSM, and youth.

Drug Use

The official estimate of illicit drug users in treatment rose from 91,000 in 1994 to 350,000 in 1997. Unofficial sources cite as many as 2.5 million drug users as of 1998, two-thirds of whom are believed to inject[10]. Unlike injecting drug-using populations in Western Europe and North America, the IDU population in Russia is younger, including a larger percentage of adolescents. A study of St. Petersburg IDUs found that 89% were under age 29 and almost one-third was under the age of 19[11]. A study of IDUs conducted in Saratov oblast found 24% younger than age 20, and 65% younger than age 25.[12]

IDU populations report significant rates of risk behaviors, both in terms of drug use and sex. Research in Sverdlovsk oblast found that only 14% of IDU in Sverdlovsk always use condoms, and a majority reported sharing of needles or syringes, including 65% who use another's syringe for measuring drug dose, and 68% who share syringes to inject drugs[13]. In Saratov, 25% of female IDUs reported commercial sex behavior and roughly 66% reported sharing needles or syringes[14]

In addition, IDU populations surveyed appear to have poor skills at assessing personal risk. Fifty-six percent of the IDUs surveyed in Saratov believed themselves to be at no or low risk of HIV infection[15].

Commercial and risky sex

Concurrent with an explosive increase in drug use, the past decade has seen a marked increase in commercial and 'casual-partner' sex in Russia. Data on the size and characteristics of this phenomenon are limited. Anecdotal and qualitative studies indicate that the increase stems from the economic and social turmoil following the transition to democracy, and resulting in increased poverty among women, increased demand among men, and the opportunity for sizable material gains[16].

In addition to IDUs exchanging sex for drugs or income, extreme poverty and illegal trafficking have pushed many women into prostitution[17,18]. Lack of official residency status also marginalizes migrants from former Soviet republics, and socio-economically disadvantaged regions within Russia, resulting in economic hardship and prostitution. Among female youth surveyed at juvenile detention centers, 45% reported exchanging sex for money. A similar percentage (52%) of women surveyed at homeless detention centers also reported exchanging sex for money[19].

While the nature of sex work is only poorly understood in the major urban centers of Russia, it is even less understood in other parts of the country (including along long-distance trucking routes, at border crossings, industrial or mining centers, military installations, or other high risk environments). Formative research on commercial sex work conducted by SANAM and the US Centers for Disease Control and Prevention (CDC), suggest that sex workers in Moscow can be roughly grouped into: 1) those practicing sex for survival (often homeless); 2) street-based sex workers working independently or controlled by pimps; 3) sauna or brothel based sex workers; 4) hotel, night club and escort service sex workers.

A KAP conducted by PSI in Saratov oblast recruited sex workers from streets, escort services, and truck stops. Of 385 women surveyed, 28% were younger than 18 years old, and 64% were younger than 25 years old. Twenty-two percent were current students. Roughly one-third reported a monthly income of less than 2500 rubles (US$78), one-third reported between 2500 and 5000 rubles (US$78-156) and one-third reported greater than 5000 rubles. Twenty-six percent of sex workers surveyed reported twenty or fewer clients; 30% reported 21-40 clients; 25% reported 41-80 clients; and 9% reported greater than 80 clients in the past month.

The level of specific risk and protective behaviors among sex workers are largely unknown except for a limited number of studies with specific populations. PSI's 2000 study of sex workers in Saratov oblast found that only 49% reported always using condoms (falling to 35% among FSW 15-19 years old). A similar percentage (44%) was found among hotel-based sex workers in St. Petersburg[20], and among male and female youth at juvenile detention centers (43%, although this figure combines both male and female youth, and both those reporting commercial sex and those who do not).

As would be expected, high rates of drug use are found among sex workers. PSI's study in Saratov found that 54% of sex workers reported using drugs >1 time/week and 51% reported having ever injected drugs. Of those reporting injecting drug use, greater than half reported sharing needles or syringes.

Males who have sex with males

Very little information is available on MSM populations in Russia. A behavioral survey conducted in St. Petersburg in 2000 among 434 men at gay clubs[21] found a number of risk behaviors, including: high rates of commercial sex (21% reported paying for sex and 23% reported being paid); high rates of STI treatment (32%); high rates of unprotected sex (38% reported unprotected anal sex in the past 3 months); and low rates of consistent condom use (43% of those reporting anal sex in the past 3 months reported consistent condom use).

Although drug use was not a part of this study's focus, anecdotal evidence suggests high rates of drug use among this population. The combination of drug use, commercial sex, and the high degree of reported bisexual behavior (79% reported ever having female

partners, and 37% reported female partners in the past 3 months) increases the risk of rapid bridging from and to on-going epidemics and the broader population.

Youth

From the evidence presented above, it is clear that youth make up a significant percentage of IDU and sex worker populations. Youth also represent a significant percentage of those newly HIV infected in Russia. However, it does not automatically follow that youth as a whole are a 'high risk' group. For example, while youth under age 18 may make up a significant segment of FSW and IDU populations, the percent of youth engaging in commercial sex and IDU is small (for example, in a survey of youth in Saratov[22], 1% of both male and female youth aged 15-17 reporting having ever injected drugs, and roughly 0.3% of female youth aged 15-21 reported having received money for sex). A clear majority of this group are low-risk, by evidence of the following: less than 4 in 10 youth age 17 or younger have ever had sex[23], sexually experienced youth report relatively few partners in the past 12 months[24]; and a relatively high percentage of sexually active youth report using condoms[25]. Distinct subsets of youth, however, report vulnerability and high-risk behaviors including exposure to sexual violence[26] and multiple partnerships[27].

The overlapping identification of youth in the previously discussed IDU and FSW populations underscores the ability of focused interventions with these populations to also reach youth. Nonetheless, it may be of value to consider the distinct characteristics and vulnerabilities that youth within these target populations represent. While youth may be a significant percentage of FSW or IDU populations, they may be underserved by existing outreach programs, or require specifically tailored programs to address their needs.

Youth may be marginalized by outreach programs because of the increased legal questions of reaching this population, or the unfamiliarity with techniques for reaching youth on the part of the outreach NGOs. Alternatively, youth are often unfamiliar with the services NGOs provide, and are less able to seek out the information and support they may need. In addition, youth in SW and IDU communities may be in exploitative settings that actively prohibit or discourage outreach. For example, youth often face increased obstacles to STI care due to unfamiliarity with medical care, lack of mobility or inconvenient hours of service, distrust or discrimination on the part of medical workers.

Response to the Epidemic by the Government of Russia and International Donors

Russian Government Response:

In recent years the Russian Government has demonstrated an increased readiness to confront the country's HIV/AIDS crisis. This change is reflected primarily in the government's recognition of the growing need for more aggressive preventive measures, and by its increasingly open view of NGOs and the role they can play in addressing the epidemic. This latter point is especially noteworthy given the government's traditional wariness of the NGO community. USAID's role in supporting PSI activities, and PSI's collaborative approach with government partners, appear to have contributed to this positive development.

Such changes within the government are still relatively modest, however, compared to the magnitude of the problem. There is still little coordination among the several state agencies responsible for addressing various medical, legal and/or social aspects of the epidemic; and in keeping with long-standing, Soviet-era practice, HIV/AIDS is treated primarily as a medical issue. HIV testing is pervasive, although the value of the data collected for effective program design and for forecasting the future course of the epidemic has been limited. The legal system's treatment of drug users and sex workers emphasizes containment and punishment, rather than prevention and mitigation, and inhibits the introduction of outreach efforts targeted at vulnerable groups. A confidential system of voluntary counseling and testing is neither widely available nor widely utilized in Russia. Although Russian law specifically prohibits HIV testing for anyone except blood donors and medical workers who may be exposed to HIV, the law is not observed in practice. Similarly, there is a legal requirement that all persons who are tested for HIV be provided with pre and post-test counseling; but neither the financial nor trained human resources are in place to implement that law. Patient confidentiality is not widely observed following VCT or STD treatment. With the exception of SANAM, NGOs are not authorized by the federal government to provide STD services.

The Ministry of Health directs a countrywide system of 88 AIDS Centers which are nominally responsible for provision of VCT to persons who request the service, and for ensuring that HIV/AIDS patients are adequately served by various legal, social and medical services. Although they are receiving increasing regional, as well as federal funding, and have begun greater collaboration with NGOs, an overall lack of resources continues to limit these centers' capacity to fulfill their function. Regional AIDS Centers have increasingly been identified by donors to develop, test and implement innovative responses to the HIV epidemic. A common challenge faced by all of these donors and their regional partners is how to facilitate broader replication of their successful programs to other parts of the country.

Another promising development at the federal level is the government's recent decision to establish a multi-agency committee--chaired by either the deputy prime minister, the prime minister or the president--to direct a government-wide response to the HIV/AIDS epidemic. Neither the specific tasks nor the budget for this body have yet been

established; but if it is empowered to act as forecast, it has the potential to spark a more expansive and responsible federal level role in confronting the crisis. Finally, the MOH has indicated informally that it intends to strengthen the scope and content of HIV/AIDS-prevention messages in the Ministry's information/education/communication (IEC) programs.

International Donor Response

USAID

USAID began working on HIV/AIDS issues in 1995 through a broader reproductive health program (primarily addressing STIs, and providing small grants to NGOs). A more significant effort to respond to the epidemic has been underway since 1998, stemming from the 1997-1998 U.S.- Russia Health Committee meetings, and culminating in the signature of a Joint Statement on the Prevention and Control of Infectious Diseases in March, 1999. The U.S. Government made a commitment to assist with the development of HIV/AIDS prevention approaches for Russia. The Russian Government identified six priority areas of assistance for future collaboration. These were:

1. HIV/AIDS prevention among injecting drug users (IDUs);
2. Education programs for vulnerable youth;
3. Generalized "safe sex campaigns" that include the use of mass media, condom social marketing and distribution activities;
4. Training of outreach groups/peer education programs;
5. Partnering U.S. and Russian NGOs that work in the area of HIV/AIDS; and
6. Improving the clinical management of sexually transmitted infections (STIs).

A 1998-2000 strategy built upon these priority areas, and identified three specific intermediate results upon which USAID defined activities. These intermediate results were:

- Improved service delivery capacity to reduce HIV/AIDS/STI transmission in selected vulnerable populations
- Improved national HIV/AIDS/STI policy environment established through a more informed policy dialogue
- Improved systems for collaboration and dissemination of information, resources, and lessons learned.

A 2001-2003 strategy update drafted in March 2000 (but never formally adopted by USAID/Russia) emphasized a continuation of the above priorities, with an emphasis on the development of increased organizational capacity among Russian NGOs.

The **Open Society Institute (OSI)** has implemented a Harm Reduction program since 1998. OSI is currently supporting 35 HR projects (average cost: $25,000-35,000 per project) in 31 regions of the country, about half of which are managed by regional AIDS Centers. OSI expects to expand its program, with DfID funding, to an additional 18 sites by late 2002.

AIDS Foundation East-West (formerly Medecins sans Frontiers MSF/Holland) is the only international NGO currently focusing on HIV prevention, treatment, care and support among PLWA populations in the Russian Federation. AFEW's 2002-2003 ($4 million) program supports HIV prevention activities among IDUs, especially in regional prisons; safe sex media campaigns in Moscow; and nationwide training programs for health workers in HIV/AIDS prevention and in pre and post-test counseling.

UNAIDS is working with 17 regions to improve their strategic planning processes as they relate to HIV/AIDS, with special attention to the creation of HIV prevention strategies for youth and increasing the acceptability of VCT. UNAIDS is also responsible for coordinating the responses of other donors (and most notably the UN family), but has not pursued this role actively.

During 1999-2002 **UNICEF** supported a "Young People's Health and Development" project designed to promote a healthy lifestyle, including avoidance of HIV. An "Early Childhood Development" project included initiatives to prevent mother-to-child transmission of HIV. UNICEF is in the process of developing a follow-on (2003-2005) strategy that will include a stronger emphasis on HIV/AIDS prevention, and will focus especially on IDUs, SWs and street children. UNICEF will try to reach these target groups through mass media, schools, youth-friendly clinics, NGOs and AIDS Centers.

Canadian International Development Agency (CIDA) recently completed its two-year Canada AIDS Russia Project in St. Petersburg. The initiative trained professionals from eight regions in five areas ranging from epidemiology and prevention to clinical aspects of HIV treatment and care, community development and psychosocial care. A new project in Saratov focuses on the collection and distribution of epidemiological data among NGOs working on HIV prevention. CIDA is in the process of developing a follow-on (three-year, $1.5 million) program that will focus on NGO development in four regions; policy development with the MOH; and the strengthening of epidemiological and biomedical capacity of the Federal AIDS Center and affiliated regional AIDS Centers. One component of the policy development will be to improve diagnostic protocols for infants born to HIV+ mothers, reducing the timeframe for definitive diagnosis for pre- and perinatal HIV transmission to 6 months from the current policy of 2 years

Department for International Development (DfID) is providing $45 million to support a 2001-2006 strategy which is closely tied to the World Bank/TB loan discussed below. About half of DfID's resources will be used to scale up its HIV/AIDS prevention activities, most of which are focused on harm reduction. Other elements of the DfID program include grants to OSI to support that organization's harm reduction projects; support for UN activities focused on HIV prevention among youth and the UNAIDS IDU taskforce; building police support for harm reduction; design assistance for the HIV component and economic modeling study element of the World Bank loan; and financial support for an HIV knowledge program.

The World Bank has been negotiating a major loan with the Russian government for over three years. The terms and content of the $150 million program ($100 million for TB prevention and treatment; $50 million for HIV/AIDS activities) have not yet been determined by the parties, and neither the Bank nor the Russian government is prepared to predict when, if ever, the agreement will be finalized.

Strategic Response: An Overall Assessment

It is difficult to assess the overall strategic response to the epidemic given the limited time and scope of this review; however several broad themes can be highlighted:

- *Harm reduction continues to play a primary role, but coverage is inadequate.*

(Note: Dave Burrows conducted an extensive review of harm reduction programs in April 2001 for the World Bank. This section draws extensively on that assessment.)

By 2001, 48 needle and syringe exchange programs (NSEPs) were operating across Russia. Support for initial assessments and establishment of these programs has been principally through MSF, OSI, and DfiD. The programs have enlisted the collaboration and support of local authorities, including police, and have built capacity of government and non-government organisations.

Most programs have been operating for less than two years and offer a wide range of harm reduction materials, educational materials and services. Of a subset of 26 NSEP surveyed by Burrows, harm reduction programs were found to be provided by a mix of organizational types: 11 were NGOs, one a collaboration between an NGO and two government agencies (an AIDS Center and narcological dispensary), and 14 were government agencies: five AIDS Centers, three narcological dispensaries, and the remaining six were combinations of government agencies (mostly AIDS Centers and narcological dispensaries working together).

Programs surveyed provided a range of types of needles and syringes and a high percentage of programs provided condoms (often provided by PSI). The distribution of educational materials was widespread, and materials covered a large number of relevant topics, though concerns were raised about the quality of the materials.

Among weaknesses cited by the assessment, few programs were found to work with sexually transmitted infection (STI) clinics to ensure that IDUs with STIs receive prompt treatment, and that transmission of STIs and sexual transmission of HIV is addressed. There was little evidence that clients were being asked what services they need (apart from the types of needles and syringes they require), and that NSEPs were adjusting their operations to meet these needs.

Preliminary results from Grund et al (2001)[28] and Power (2001)[29] clearly demonstrate that NSEPs are having an impact on individual behavior change; however, serious problems with the reach and quality of services were noted. NSEPs working at their current coverage rate (below 5%) will have little or no effect on the HIV epidemic in Russia.

Two overall goals for increased reach were identified in the Burrows assessment. First, in the cities where they exist, harm reduction programs need to increase access to their programs (and to needles and syringes outside their programs) as quickly as possible.

Second, NSEPs need to open in other cities in each oblast where one NSEP now works, as well as in the 55 territories with no programs.

The reach of existing NSEPs must increase by a very large amount, in most cases by at least 10 times and in some cases up to 100 times their current level in order to reach the 60% coverage level which is felt to be a minimum threshold for containing HIV epidemics in IDU populations. Unfortunately, the largest donor in this sector, DfiD, is proposing to use the bulk of its US$37 million project to focus upon the development of a 'model' intervention and scaling up in only two regions (Volgograd and Altai). USAID, moreover, is prohibited by law and agency policy from supporting NSEPs.

- *Targeted interventions with sex workers and MSM have been extremely limited.*

Programs targeting sex workers have been conducted by USAID (through PSI in Saratov, and SANAM/CDC in Moscow) and by AIDS Infoshare (in Moscow oblast). PSI has also conducted programs through the partnership program with Stonewall and local NGOs affiliated or formally affiliated with the NAMES project, targeting MSM in Moscow.

SANAM/CDC's efforts were targeted principally with marginalized youth and adults practicing sex for survival and with street-based sex workers with slightly higher incomes. Interventions were limited by the medical approach of SANAM (emphasizing improving STI care and referrals) within the context of detention centers. While this approach does allow for certain advantages in terms of providing a safe point of contact and relative ease of access (at least for diagnosis, if not for follow-up), it also provides distinct disadvantages. Reaching sex workers in their environment builds greater trust and allows outreach workers to better understand the context and constraints facing target populations. It also allows sex workers to develop into program leaders and peer educators, and allows for attempts to collaborate with gatekeepers (such as pimps or mamochkas'). PSI's work with the NGO Accent has incorporated some of these approaches, as have AIDS Infoshare.

Recognizing the significant overlap in IDU and sex worker populations, eight existing harm reduction programs also report specific sex worker targeted activities. These programs are based in: Balokovo, Kazan, Krasnoyarsk, Novorossiysk, Penza, Pervouralsk, St. Petersburg, and Volgograd.

In addition to outreach, there is an urgent need for increased advocacy and policy change to address the significant obstacles, abuse and discrimination faced by these two populations. Advocacy on the part of SANAM/CDC to improve STI diagnostics and treatment for individuals detained in either pre-jail, youth juvenile or adult homeless detention centers may result in some degree of improved care; however, large institutional obstacles remain.

- *Youth and general population efforts have provided largely diffuse messages*

Youth and general population IEC campaigns are important to reduce stigma and to support more targeted interventions, however they have only limited effectiveness in behavior change among the general population. In Russia, general population campaigns conducted to date have included PSI's media campaign based upon the slogan, 'Take it with you'. This campaign has been conducted through traditional mass media and through the Internet. Evaluation of the Internet approach through counting web page 'hits' indicates considerable success in reaching viewers - approximately 6-10 million hits were found over the course of a 7-10 day campaign (representing as much as one-half of the number of typical internet users in a one week period). However, information disseminated through general mass media or the Internet is likely to miss those individuals who are most at risk, and is unable to provide the type of information to individuals, which effectively changes individual risk perception, improves condom-negotiating skills, or causes sustained behavior change.

PSI has also supported radio programs linked with telephone hotlines in Saratov, which, while providing more potential for interactive, person-to-person behavior change communication, is also limited in reaching the most vulnerable populations. Nonetheless, these programs, if engaged in 'pushing the envelope' by providing more explicit messages about prevention methods in mainstream media, can generate positive changes in social norms over time. Unfortunately they require considerable, sustained investments to achieve any effective level of widespread coverage in a country as large as Russia.

In the future, both UNICEF and DfID propose mass media efforts to strengthen government and popular support for HIV/AIDS prevention to reach youth and general populations. UNICEF has also proposed school-based campaigns.

- *STI treatment protocols have been improved, but implementation is uncertain and accessibility by marginalized populations is poor.*

CDC's support of SANAM has strengthened appropriate STI treatment protocols through the translation of CDC/WHO guidelines and training of a wide range of health care providers in a number of regions across Russia. Improved STI care has been mandated through official Ministry of Health policy. In addition, SANAM has supported appropriate care through the publication of a scientific journal (STI) and the development of IEC materials and support of a 'model' STI clinic.

Effective implementation of the STI guidelines is uncertain, and likely represents a range of experience depending upon the resources and commitment in various regions. Institutional obstacles continue to prevent the expansion of effective care to marginalized populations. For example, the lack of residency permits results in refusal of treatment to many high-risk adults and adolescents in Moscow.

- *Condom availability and accessibility is encouraging, but concerns about the reliable supply of high-quality condoms remain.*

There are a wide variety of condoms available on the Russian market. According to PSI's study of the condom sector, the most popular ('affordable') price for condoms is less than 8 rubles for a pack of three. Currently, three brands of condoms which have been certified "GOCT" (meaning they have been tested to international quality standards and certified by the Russian Ministry of Health) are within this price range: 'Exotic' by Russian manufacturer Pentcroft, 'Desire' and 'Kasanova' which are both imported from India.

Affordability and accessibility of condoms appear to be quite high, based upon behavioral studies measuring 'ever' use of condoms, and PSI's KAP studies which ask specific questions about condom access. For example, among adolescents surveyed in juvenile detention centers, one-half of whom report an income of less than 200 rubles ($7) in the past month, 43% report always using condoms[30]. Among female sex workers in Saratov surveyed in 2000[31], 94% report 'always' or 'most of the time' using condoms with clients in the month before the survey. Of those reporting not using a condom during their last contact with a client (19%), the explanation that they are too expensive was given by only 6% (or a total of 5 of 385 FSW surveyed). Eighty-two percent (82%) of FSW surveyed reported no significant difficulty in buying condoms.

Among IDUs surveyed in Saratov in 2000[32], difficulty in purchasing condoms was not assessed to be a major obstacle: 59% reported that they could 'very easily' purchase condoms, and only 5% reported that it was 'somewhat difficult'. No individuals reported price as the reason for not using condoms during last sexual contact.

Among youth surveyed in Saratov in 2000[33], no respondents reported that the price of condoms were an explanation for their non-use of condoms with their last 'casual' partner. While a high number (48%) reported that condoms 'were not available', this explanation likely reflects a lack of commitment to condom use rather than general availability or accessibility of condoms.

2002-2005 USAID/Russia HIV/AIDS Strategy

As described above, the Russian HIV/AIDS epidemic can be characterized by low current prevalence but explosive growth, concentrated among sexual and drug using networks in specific regions across Russia. While having many unique characteristics, the Russian epidemic provides an opportunity to put into place many of the lessons learned and best practices defined in previous concentrated epidemics in Western Europe, North America, and Asia. Recommended strategies for effective response in these settings include:

1. Implementing focused, effective behavior change communication (BCC) programs targeting individuals at high risk of HIV infection.
2. Increasing the availability and use of epidemiological data for expanded, effective HIV/AIDS programming and policy development.
3. Building strong networks of public and private sector organizations involved in the implementation of recognized best practices and lessons learned.

The specific context of the Russian epidemic, with high numbers of STI infections among populations outside of the formal health care infrastructure, and widespread government sponsored HIV screening, demands two additional strategies to insure an effective response:

4. Expanding access to quality STI services for marginalized populations.
5. Improving the provision of counseling in VCT settings.

Two over-arching considerations will guide the translation of these general strategies into the specific activities to be conducted under the defined intermediate results: a) the necessity of maximizing coverage to improve the likelihood of impact and b) the focusing of activities within three regions of Russia. The proposed 2002-2005 HIV/AIDS strategy, limited to the Moscow, Saratov and Samara regions will nonetheless cover a population of greater than 20 million people, and span a combined geographic area larger than the United States east of the Mississippi. Hence, to reach any significant level of coverage, this strategy will emphasize reaching especially vulnerable populations (which have epidemiological significance as potential bridging populations) and leveraging increased coverage through the implementation of programs within NGO networks and through the collaborative implementation of programs co-funded by other donors and regional and federal governments. In particular, programs with IDUs, sex workers, and MSM will be emphasized, paying particular attention to the needs of adolescents within these groups.

To support these defined strategies and take advantage of key comparative advantages held by USAID vis-à-vis other donors in Russia, and working within the larger Strategic Objective defined by the USAID Russia Mission, "*Use of Improved Health and Child Welfare Practices Increased,*" a framework of three key intermediate results have been defined, as follows:

USAID/Russia HIV/AIDS Intermediate Results

Intermediate Result 1: Improved Service Delivery to Reduce HIV/AIDS Transmission Among Marginalized and Vulnerable Population Groups

IR 1.1: Improved BCC outreach to vulnerable population groups
IR 1.2: Improved STI care provided to vulnerable population groups
IR 1.3: Improved VCT services for vulnerable population groups

Intermediate Result 2: Epidemiological data used to improve HIV/AIDS programming and policy development.

IR 2.1: Improved availability of data
IR 2.2: Improved capacity for the design, analysis and interpretation of behavioral data
IR 2.3: Improved use of data in programming and policy development

Intermediate Result 3: Improved Replication, Adoption and Use of Lessons Learned.

IR 3.1: Russian NGO and regional government networks strengthened to support the broader implementation of piloted activities

Intermediate Result 1: Improved Service Delivery to Reduce HIV/AIDS Transmission Among Marginalized and Vulnerable Population Groups

Overview: A comprehensive HIV/AIDS prevention strategy in Russia requires steps to strengthen local institutions that can provide effective behavior change communication (BCC); improve the accessibility and quality of STI care; and develop a more effective approach to voluntary counseling and testing. Approaches will build on existing systems and structures, and utilize a variety of channels, including targeted mass media and traditional and interpersonal communication to stimulate discussion and action on the key issues that motivate and support behaviors.

Over the last decade, many lessons have been learned on how to apply basic BCC strategies in the Russian Federation. The greatest of these is the need for systematic assessment and planning, coupled with monitoring and evaluation, to ensure the development of BCC strategies that will have the greatest impact and use limited resources most effectively. Similarly, by strengthening the capacity of local institutions in strategic assessment and planning related to improving points of contact for STI care, and for providing an integrating voluntary counseling and testing services, more cost-effective programs can be developed to maximize impact among the most vulnerable populations.

IR 1.1: Improved BCC outreach to vulnerable population groups

Rationale: The key high-risk groups identified for Russia are IDUs, SWs and MSMs. These groups continue to be most affected by the epidemic, and are most likely to spread the epidemic into broader populations and as-yet uninfected communities. Working with populations with high levels of risk behaviors during the early stage of HIV epidemics is the only proven means of averting a devastating widespread epidemic, and provides the most cost-effective strategy for addressing the current stage of the Russian epidemic. Formative research with each of these target populations indicates that there is considerable overlap between these groups, and that youth make up a considerable percentage, if not a majority, of each.

Program Response: BCC activities in Russia have been developed to varying degrees for each of these groups; but there has been little systematic work to date in the development and implementation of a consistent, holistic strategy to address behavior change among high-risk population groups, and especially high-risk behavior among youth. Moreover, representatives from high-risk populations themselves have not been sufficiently involved in the development of activities (beyond their participation in occasional surveys). The following is an illustrative list of the kinds of activities that will be undertaken to effect lasting behavior change among Russia's high-risk population groups:

- Conduct an inventory of potential NGO and local government counterparts willing to engage in BCC approaches to high-risk behavior

- Provide limited capacity-building support for these partners by engaging them in activity design and implementation.

- In collaboration with already established Russian NGOs, undertake formative research/needs assessment with broader involvement/representation of stakeholders through the use of focus groups, and the recruitment of individuals from high-risk groups into project staffing and governance.

- Continue the 'Take it with you' safe sex mass media campaign with PSI, but encourage greater partnership with Russian NGOs and the involvement of a Russian governmental counterpart. Discontinue support for Internet delivery of BCC messages. Although the Internet appears to be the fastest growing communications market in Russia, high-risk groups (IDU, MSM, FSW) do not frequent Internet salons or have access at home. Reduce reliance on entertainment events since results show that less than 5 percent of visitors recall safe sex messages disseminated at such events.

- Expand cooperation with NAN and other NGOs in Saratov Oblast to extend outreach, and to increase peer educator coverage among high-risk groups. Increase the use of roundtables, conferences, and other forums in Saratov and Samara to exchange experience, lessons learned and best practices. Encourage direct involvement from members of IDU, MSM, and FSW populations in these forums as a means to reduce stigma and improve leadership and ownership of these programs.

- Encourage Russian NGO and government counterparts to take leading roles in the strategy design and implementation process. Initiate linkages with the newly established Information Unit in the Ministry of Health.

- Consider discontinuation of PSI's branded condom program ("Favorite") if an analysis of that program's performance and cost effectiveness does not demonstrate a significant advantage of that program over more generic efforts to promote condom use.

- Expand the number of information distribution channels (in target, as well as other regions) by enlisting the participation of organized and unorganized, official and unofficial intermediaries such as youth organizations, AIDS Centers, prison directors, local law enforcement bodies, pimps, the Russian Red Cross, OSI, etc. Increase the production of informational print materials that can be used by these organizations.

- Try to expand the airtime and geographic coverage of local radio broadcasts such as the "Minus Virus" program in Saratov and its associated hotline. Encourage marketing of the format to national radio stations, preferably a mix of state owned and private radio stations (e.g., Radio Rossii and Russkoe Radio). Include user-relevant information in radio broadcasts, including reference to clinic/youth center locations, hours of service, telephone numbers, assurances of confidentiality, etc.

- Expand successful social marketing models to other high-prevalence regions, to the extent possible with available financial and management resources.

Expected results by 2005:

- Improved, focused condom social marketing programs in three target areas
- Outreach to reduce high-risk behaviors among IDUs, SWs, and MSM.

IR 1.2: Improved STI care provided to vulnerable population groups

Rationale: Sexually transmitted infections (STIs) impose an enormous burden of morbidity in Russia, in addition to facilitating the sexual transmission of HIV. Therefore, improving referral and treatment of STIs is part of a comprehensive strategy for HIV prevention. BCC and condom social marketing contribute to reducing the rate of new STIs; but prompt, effective treatment is an essential complementary strategy. Interventions to improve the health-seeking behavior of high-risk population groups will include the following:

Russia's syphilis epidemic serves as both a warning and an indication of the institutional failure of current STI control programs to effectively reduce transmission. Obstacles to treatment include the inability of individuals with STI symptoms to access health services, (e.g.., non-Muscovites/non-Russians are not able to access public clinics in Moscow); the dysfunction of current systems of screening, diagnosis and treatment, and the inadequate treatment protocols currently provided. On-going efforts by the MOH in cooperation with CDC are attempting to address the latter of these two obstacles (treatment protocols); however the former (inadequate access services) still constrains an effective response to the country's STI epidemic. SANAM, for example, is the only NGO officially authorized by the Russian Government to provide STD services.

Program Response: As a follow-on to ongoing efforts to improve STI diagnosis and treatment protocols, special attention will be given to the development of outreach efforts that reach vulnerable populations. Some of these activities intended to reinforce improved health-seeking behaviors within targeted populations include:

- Behavior change messages that provide information about the prevention, complications and treatment of STIs

- Peer education regarding the availability and importance of STI care organized through NGOs prepared to provide outreach services for targeted populations.

- Improved collaboration with identified sources of quality STI care.

- Training for health care providers to improve their delivery of BCC messages concerning STIs and condom promotion; encouragement, as part of this training, of non-judgmental and sympathetic treatment of STI patients by health care providers
- Technical assistance to improve the STI treatment capability of selected NGOs which already offer reproductive health services to marginalized populations
- Improved referral services for youth, homeless adults and sex workers in detention centers.

USAID will also engage in policy dialogue with the Federal Government to identify and remove legal, regulatory and procedural barriers which impede access to STI/STD services. These include residency criteria, prohibitions on the ability of NGOs to provide STD services, inconsistent observance of STI case management protocols, and quality of care factors (including confidentiality and partner notification issues).

Expected results by 2005:

- Improved service delivery capacity of SANAM
- Improved vulnerable groups' access to STI services

IR 1.3: Improved VCT services for vulnerable population groups

Rationale: Under Russian law, every medical or other facility that conducts HIV testing is required to provide both pre and post test counseling for clients/patients. In practice, the testing itself is frequently involuntary, not always confidential, and counseling services are often minimal or non-existent. In this environment, the significant potential of VCT services to help stem the HIV epidemic is lost.

VCT is an essential component of an HIV prevention program. People who have chosen to be counseled and then have gone on to have an HIV test have, in limited studies, registered some behavior change that should contribute to lower rates of HIV spread[34]. The ready availability of VCT services is also thought to be a factor in reducing stigma surrounding HIV and in encouraging community support for those affected. Perhaps most importantly, VCT services are an essential early entry point to social support services and medical and associated care for those infected with HIV. Finally, the voluntary counseling and testing of pregnant women can help reduce the transmission of HIV from mother to child. With specific regard to conditions in Russia, VCT can play a powerful role in a country with an almost pervasive HIV screening system, and in a setting characterized by extraordinarily high numbers of STI cases among youth who rarely use the formal health system.

Program Response: An effective response to the lack of quality VCT services in Russia will be constrained by the strongly-held official (Russian government) position that these services are already in place. More encouragingly, Russian NGOs and government bodies at regional levels, including regional AIDS Centers, are far more receptive to the

need for quantitative and qualitative improvements in VCT. The three thrusts of the 2002-2005 strategy will therefore be to work with the federal government to 1) develop improved policies as they relate to VCT—with such policies to be informed by the development and operation of model VCT services in government and NGO facilities; 2) work with regional bodies in three oblasts (Moscow, Saratov and Samara) to expand the availability of quality VCT services in government and non-government facilities, especially for at-risk youth; and 3) the development of outreach links and referral services that will improve at-risk youth access to VCT services. The key components of this strategy will include:

- *VCT Policy Development with the MOH*: As noted above, the law relating to VCT in Russian medical facilities is clear (although ambiguous with regard to testing in non-medical locations). Still needed, however, are 1) practical guidelines and protocols that would set forth how the law is to be adequately, fairly and ethically applied in practice; and 2) more rigorous enforcement of existing policies and operational procedures regarding medical follow up of HIV-positive patients to TB, STI, AIDS treatment, drug treatment services. Under the 2002-2005 strategy, CDC would seek to build upon its long-standing relationship with the MOH by developing these guidelines, protocols and procedures with MOH partners. The objectives of these effort would be the development and issuance of an MOH directive that would establish the minimum standards for provision of quality VCT services in MOH facilities, and the consistent observance of patient follow-up protocols.

- *Development of Model VCT Services*: The MOH directive discussed above would be based in part on the practical experience to be derived from the development and operation of model VCT services—one in a Moscow-based MOH facility, and one in an NGO facility in either Saratov or Samara. The Moscow-based model would be developed in cooperation with CDC or another appropriate cooperating agency. The NGO model would be developed with assistance from a USAID cooperating agency (CA) such as Engender Health or FHI/IMPACT. A technical advisory group (TAG) comprised of participants from the MOH, CDC, the NGO and the CA would be established to exchange experience and best practices with special attention to their respective efforts to attract and serve at-risk youth to the two model services. Selected additional NGOs involved in the Partnerships Program (see below), PSI, and representatives from regional AIDS Centers, STD centers, drug centers and family planning centers in Saratov and Samara, would also serve on the TAG to facilitate rapid dissemination of experience emerging from the initiative.

- *Replicate VCT Services in the Three Target Regions*: Many government medical facilities in the three regions will already have nominal VCT services in place (sometimes with quality counseling services provided by on-site NGO personnel). NGO-based VCT services are not yet available/allowable—an issue to be addressed in the course of the policy development work discussed above. Under the 2002-2005 strategy, USAID will support efforts to improve the quality of VCT services where inadequate services are now in place or where such services are absent. Given resource constraints on the USAID program, this will be largely a technical task (i.e.,

a proactive effort to take the lessons and best practices that emerge from the model VCT services discussed above, and disseminate those lessons to local facilities and institutions willing to provide quality VCT services). Candidate sites will include local skin and dermatology dispensaries, AIDS Centers, drug centers, family planning sites, NGO youth-friendly clinics (to the extent allowed by law), and private/commercial health care institutions. NGOs participating in the Partnerships Program will play an important supportive role in this effort. Technical assistance for this replication and expansion initiative would be provided by a USAID cooperating agency—possibly the same CA selected to help develop model VCT services in an NGO setting (see above).

- *Development of Outreach and Referral Activities in Support of VCT Services*: PSI outreach services, including its social marketing campaign and other initiatives to reach at-risk youth will be structured to include linkages and referral services to locations where quality VCT services are available. Information will be specific and client-useful, e.g., it will explain where services are available, what services can be found at the site(s), operating hours, telephone numbers, assurance of confidentiality, etc. Special attention will be given to ensuring that the outreach efforts of NGOs participating in the Partnerships Program are strengthened to ensure VCT linkages and referral services for at-risk youth.

Expected Results by 2005:

- Two model VCT clinics in operation (one in Moscow/one in Saratov or Samara)
- MOH policy directive on quality VCT services issued
- Quality VCT services installed in XX medical and NGO facilities in Moscow, Saratov and Samara
- All USAID-supported outreach efforts include VCT linkages and referral services for at-risk youth

N.B. Implementation of IR 1 and its sub IRs would be preceded by the development of a comprehensive communications workplan. This plan would identify and integrate all communications activities into a coherent and consistent action program. USAID/Russia would seek the assistance of a qualified cooperating agency to help develop this communications workplan.

Intermediate Result 2: Epidemiological data used to improve HIV/AIDS programming and policy development.

IR 2.1: Improved availability of data

Rationale: Despite the epidemiological importance of marginalized and vulnerable populations to the escalating HIV epidemic in Russia, there is a paucity of behavioral

data available on these individuals. Little is known about their specific risk behaviors, contextual environments, or attitudes towards key HIV prevention messages. Better understanding the characteristics of these populations and the high-risk environments in which program implementers can effectively reach them is essential for insuring an impact upon the epidemic in a cost-effective way.

Additionally, while interventions are concentrated on populations at increased risk of HIV infection under this strategy, collecting information on sexual networking and general population risk behaviors will allow for better understanding of general population risks and programming when general populations campaign become integral to prevention efforts.

Increasing the availability of behavioral and contextual data on both marginalized and general populations will also increase the effectiveness of advocacy efforts and the potential for expanding effective responses through the increased and more appropriate allocation of government resources. Repeated measures of key behavioral indicators also allows for a more detailed assessment of trends in the epidemic (in a more prospective and timely fashion than waiting for reported AIDS cases or HIV infection), in addition to a more robust evaluation of the effect of program activities.

Program response: Several different efforts will be undertaken to improve the availability of data, including:

- Supporting the expansion of formative data collection on high risk populations through mapping and qualitative research to improve understanding of risk behaviors and environments. Specifically, USAID/Russia will support the implementation of MEASURE's PLACE methodology to identify High Transmission Areas (HTAs) in each of the three intervention sites proposed in the this strategy.
- USAID/Russia, with the technical assistance of Family Health International, should support the implementation of two rounds of behavioral surveillance surveys with IDU and FSW populations in each of the three intervention sites proposed in this strategy.
- Support two follow-up rounds for the sexual behavior module of the Russian Longitudinal Monitoring survey (RLMS).

Expected Results by 2005:

- Results disseminated from mapping of 3 high transmission areas (HTA) in Moscow, Saratov, and Samara by 2003
- Results disseminated from BSS round 1 by 2003 and round 2 by 2005
- Results disseminated from RLMS round 2 by 2003 and round 3 by 2005

IR 2.2: Improved capacity for the design, analysis and interpretation of behavioral data

Rationale: Effective HIV/AIDS program development and implementation requires strong capacity in research and evaluation. Therefore, as part of a strategy to improve local capacity to develop, conduct, and sustain locally relevant HIV/AIDS programs, it is essential to build capacity in the design, analysis, and interpretation of behavioral data.

HIV/AIDS research which is conducted as part of one-time studies led by foreign research organizations or NGOs must work to improve the capacity of their local partners to do more than simply conduct interviews and do basic data entry. When local partners have inadequate capacity in analysis and interpretation, they also lack the ability to conduct the essential follow-on steps of advocating program and policy changes (see IR2.3). This process of institutionalization of local skills in data collection is crucial to ensure better quality as well as sustainability of program monitoring and evaluation activities.

Program response: To insure 'ownership' of the behavioral data proposed under this strategy, technical support will be provided to the Federal AIDS Center to allow them to become fully capable of supporting, and eventually sustaining, behavioral research efforts. The Federal AIDS Center, as the main source for sero-prevalence data, can play a central role in determining behavioral data collection needs; planning and coordinating diverse national, international, and bilateral agencies' research needs; and implementing the data collection approaches.

Expected Results by 2005:

- Increased technical capacity for mapping, BSS methodology, other research methodologies among local researchers (private and public sectors)

IR 2.3: Improved use of data in programming and policy development

Rationale: Epidemiological data is of little use if it is collected, collated, and never interpreted or distributed. An essential aspect of increasing the availability of data therefore is improving the use of data for the purposes of informing HIV/AIDS prevention planning, and for advocacy and policy development.

The relationship between HIV incidence and prevalence grows increasingly complex as epidemics mature, making the type of mass screening performed in Russia, less and less informative. In response to this, UNAIDS promotes the development of "second generation" surveillance systems, in which behavioral data collection is an integral and complementary component to HIV sero-surveillance. The interpretation of this data,

while more informative, is more complex, and requires more detailed analysis than simple reporting of numbers of individuals screened and numbers found positive.

Finally, the greater availability and sophistication of relevant HIV/AIDS data will allow for more sophisticated modeling and policy presentations to key decision-makers within Russia - at both regional and national levels.

Program response:

- Coordinating joint reports which combine biologic and behavioral data and report to specific target populations, regions, and age cohorts to allow HIV/AIDS implementers greater facility at interpreting the results and translating to their programs.
- Improving the sharing of data with stakeholders and representatives of targeted communities and PLWHA.
- Improving advocacy by incorporating sophisticated yet simple and powerful presentations of HIV/AIDS information to key policy makers at regional and national levels.

Expected Results by 2005:

- Workshops held for key target population representatives and program implementers by 2005
- Research results used for program design and implementation
- Workshops and/or presentations made to key policy makers using epidemiological data by 2005
- Policy papers published and disseminated using program data by 2005

Intermediate Result 3: Improved Replication, Adoption and Use of Successful Lessons Learned.

Overview: There have been few successful efforts in Russia to disseminate and replicate "model" or demonstration programs elsewhere in the country. This experience strongly suggests that the sharing of information about best practices and lessons learned will not by itself lead to the replication of good programs. A more effective mechanism is needed—one that would involve the actual export and replication of successful programs, particularly in a manner that would demonstrate their usefulness in partnership with Russian government agencies. Russian NGOs are increasingly poised to assume this role.

IR 3.1: Russian NGO and regional government networks strengthened to support the broader implementation of piloted activities

Rationale: Further to Russia's designation as an intensive focus country, USAID/Russia's HIV/AIDS strategy should seek to significantly expand the coverage of USAID-supported activities carried out under that strategy. Even in the absence of this requirement, USAID/Russia has in the past acknowledged the importance of coverage, as reflected in its selection of target areas (Moscow city, Saratov and Samara oblasts) where the number of HIV cases and/or the rate of growth of the HIV epidemic is especially high. Actual coverage of at-risk population groups within these regions is still low, however. A strategic response is therefore needed that will significantly expand population coverage within the targeted regions, and to the fullest extent possible, to other regions of the country.

Like other donors in Russia, USAID/Russia has supported innovative programs in selected regions of the country in the expectation that successful efforts in these target regions can be replicated. Most donors, including USAID, have therefore supported information-sharing mechanisms to promote the dissemination of the lessons learned and best practices which emerge from their various programs. Thus far, however, these dissemination efforts have contributed to only limited expansion and/or replication of HIV/AIDS activities. A strategic response is needed that will better ensure the expansion and long-term sustainability of USAID-supported initiatives in target regions and elsewhere in the country.

Program Response: The NGO Partnership Program has shown that "mentor" NGOs can successfully transfer new skills and practices to other NGOs. Moreover, the collaborative relationships that some Russian NGOs have established with government partners--e.g., between SANAM and the Ministry of Health, between ACCENT and the Ministry of Defense, and between a local NGO and the AIDS Center in Saratov—have demonstrated some working models for the wide scale replication of comprehensive services that can reach larger numbers of at-risk youth. During 2002-2005 USAID/Russia will support activities that draw on and expand the most positive features of the Partners Program and on the experience of NGOs that have successfully extended their "reach" and

sustainability by partnering with government institutions. Elements of this strategy will include:

- *Increased Reliance on Russia-to-Russia partnerships*: Program experience with US NGO-to-Russian NGO partnerships has been generally positive. Most of the participating US institutions have been very effective in training their Russian partners in innovative but tested ways to reach vulnerable youth with the information and services they need to prevent HIV/AIDS. The cost of such international partnerships is high, however—as is the management and logistical burden implicit in such arrangements. In addition, US partner institutions often require lengthy "learning time" before they can be effective in the Russian context. More importantly, two developments over the past few years suggest that a greater reliance on Russian-to-Russian partnerships is now in order. First, several Russian NGOs (e.g., Accent, SANAM, NAN) are now in a position—in terms of their institutional, managerial and technical depth—to serve as mentor NGOs themselves. (Indeed, some of these NGOs are in this position because of their prior roles as beneficiaries of the Partnerships Program). Secondly, the Russian government, at both federal and regional levels, is displaying an increased readiness to work collaboratively with the NGO community. Steps taken now to cement such ties will help ensure a long term role for Russian NGOs as one of the government's strategic partners in responding to the country's HIV epidemic. Under the 2002-2005 strategy, USAID may decide on a case-by case basis to engage additional US mentor NGOs; for the most part, however, the Partnership Program will rely far more heavily on Russian NGOs to expand the network of Russian NGOs undertaking quality HIV/AIDS prevention programs among vulnerable youth.

- *Increased Attention to Networking*: Russian (and selected US) "mentor" NGOs will be selected on the basis of their institutional and technical competence to play the challenging roles of model, mentor and trainer to Russian NGOs. An additional criterion to be applied to potential partnerships under the 2002-2005 strategy will be their potential to engage a larger number of NGOs in each partnership. Under the current strategy, partnerships comprise a one-to-one relationship. Under the new strategy, special priority will be given to partnerships that link a mentor NGO (US or Russian) to Russian NGOs that themselves are part of a larger group. Examples might include NAN (ten affiliates throughout the country); chapters of the Russian Red Cross; regional and/or municipal Rotary Clubs (43 chapters currently implement health programs); Accent, AIDS Infoshare, The Siberia AIDS Network, etc. (USAID/Russia should conduct a census/inventory of NGOs in Russia—including those currently involved in the health sector as well as those outside the health sector but interested in addressing the HIV/AIDS epidemic, to identify potential NGO partners). The object of the partnerships would be to develop model interventions with a "lead" partner, and to prepare that partner to continue second and third generation training of its affiliated chapters/units throughout the country. Further to a suggestion by one of the NGOs in the Partnerships Program (NAN), USAID support for such partnerships would put special emphasis on a "training of trainers" component, and would include the travel and transportation resources which the

"lead" NGO would need to carry training outward to its NGO affiliates elsewhere in the country. [This component of the strategy would also support the creation of linkages with NGO programs developed in St. Petersburg and Kaliningrad under the Baltic Sea Initiative].

- *Support for NGO/Russian government collaboration*: As noted previously, the Russian government is adopting an increasingly favorable, if still informal policy position *vis-à-vis* the NGO community, particularly with respect to the NGOs' role in conducting outreach to SW's, IDUs and other marginalized population groups. In one sense, the government's changing posture regarding NGOs reflects the government's acknowledgment that its own resources are not adequate to the huge task. But the federal government's more hospitable position is also bringing it into line with regional governments, many of which have long welcomed a more expansive role by NGOs in addressing the HIV epidemic. The most obvious expression of this regional level collaboration has been the joint efforts of NGOs and regional AIDS Centers, whereby the NGOs have trained VCT counselors at AIDS Centers; and conducted outreach and provided referral services for at-risk populations served by the AIDS Centers. Under the 2002-2005 strategy, USAID will target assistance resources on NGOs that demonstrate their readiness and competence to work constructively with Russian government partners in the implementation of outreach and comprehensive service delivery programs. Special emphasis will be given to NGO partners that are prepared to replicate successful outreach and service delivery models which have been developed elsewhere by USAID and/or other donors or implementing organizations. To participate in this component of the program, NGOs must demonstrate a working relationship with a government partner, including that partner's endorsement of the NGO's proposal to USAID (or to the organization chosen by USAID to manage this portion of the program). This element of the strategy would be implemented by a cooperating agency (CA) skilled in the management (including solicitation, screening, funding and oversight) of sub grants executed by host country NGOs.

- *Policy Dialogue with the Russian Federation:* Concurrent with the foregoing activities, USAID will engage the Russian Government in an examination of policy, legal and regulatory factors that currently constrain a more active role by the NGO community in addressing the country's HIV epidemic. The objective of this examination will be the removal of restrictions on NGOs' ability to provide STD or VCT services, and the development of effective referral linkages between public and non-government service networks.

Expected Results by 2005:

- Russian NGOs conducting high-quality outreach and service programs for marginalized, vulnerable youth
- Regional AIDS Centers conducting collaborative programs with NGO partners
- Pilot/demonstration projects replicated by NGOs and/or NGO/government partners in other regions of the country.
- A Russian Government policy environment supportive of a more active role by the NGO community in addressing the HIV epidemic

Summary Matrix of Illustrative Program Activities

IR	Illustrative Activity	Monitoring (Process) Indicators	Implementing Agency and Partners	Budget
1.1	Prepare communications workplan Intensify social marketing campaigns targeting marginalized and vulnerable populations in Moscow, Saratov and Samara Train peer educators and outreach staff to expand outreach to marginalized and vulnerable individuals in Moscow, Saratov and Samara Support national media campaign directed to youth and vulnerable populations	Communication workplan No. of peer educators and outreach staff trained No. of media (radio and TV) spots aired % coverage achieved/per month (No. marginalized pop. reached by outreach/peer education and accessing services at resource centers)	Synergy PSI, NAN, Accent	$50K in 2002 $275K/yr for print materials and outreach activities $250K/yr for training and salary support to outreach workers $750K/yr for radio & TV $50K/yr for public events
1.2	Promote STI services through outreach activities Strengthen youth-friendly clinical STI services	No. at-risk individuals who receive STI/VCT services No. of clinics providing youth-friendly STI services	PSI, NAN, MOH, SANAM, Accent, other Partners	$85K/yr for outreach activities and materials development $100K/yr to strengthen clinical services
1.3	VCT policy development with MOH	MOH Policy directive written	MOH, CDC	$100K/yr
	Develop Model VCT services in Moscow and one region	Two model services established	MOH, CDC, SANAM other CA (TBD)	$100K/yr
	Replicate VCT services in three regions	Three services established	MOH, CA (TBD)	$200K/yr
2.1	Conduct PLACE study in 3 sites	No. of sites mapped	MEASURE/UNC	?/yr1
	Conduct BSS with IDU and FSW in 3 sites	No. of reports submitted	IMPACT/FHI	$250K/2003 and 2005
	Conduct sexual behavior module of RLMS	No. of reports submitted	RLMS/UNC	$80K/2003 and 2005
2.2	Provide TA/training in mapping and behavioral research	No. of TA visits	MEASURE/FHI	
2.3	Results of research disseminated to key policy makers	No. of workshops held. No. of workshops and presentations made. No. and quantity of policy papers published and disseminated.	IMPACT/FHI IMPACT/FHI	$30K/2003 and 2005 $30K/2003 and 2005
3.1	Expand Partnerships Program	No. of participating partners	PSI or other cooperating agency, various partners	$400K/yr
	TOT for NGO Partners	TOT training programs	PSI or other CA, various partners	$100K/yr
	Grant support for joint NGO-Russian government programs. (emphasizing high prevalence regions such as Irkutsk and Novosibirsk)	No. of NGO-Russian joint programs No. of NGO staff in 'satellite' regions trained.	PSI or other CA, various NGOs, AIDS Centers, Skin and Dermatology centers, other	$300K/yr

OPERATING ENVIRONMENT

Relationship of the HIV/AIDS Strategy to Overall USAID/Russia Strategy

USAID/Russia's revised strategy for the period 1999-2005 identifies several themes that are addressed by the HIV/AIDS strategy proposed above. These include: 1) recognition that dangerous declines in public health—due in part to unhealthy behavior—are threatening Russia's ability to achieve its development objectives; 2) an acknowledgment that Russian institutions need to play the leading role in the country's development process; and 3) that US-Russian "partnerships" can still help further the development process, albeit in the context of Russian leadership and responsibility for that process.

The HIV/AIDS strategy discussed herein recognizes that the country's HIV/AIDS epidemic—one of the fastest growing in the world—will impose an almost insurmountable financial and human burden on Russia if it is not dramatically and immediately slowed. Indeed, failure to slow the growth of this epidemic could cripple Russia's efforts to achieve sustainable and equitable economic growth for its citizens.

In view of these very high stakes, the strategy proposes a program of cooperation with Russian Government and NGO partners, which serves primarily to build and demonstrate effective models that will succeed in the long run only if they are embraced and broadly replicated by our Russian partners in government and in the Russian NGO community.

Finally, the strategy recognizes that the technical expertise and practical experience of US institutions has immediate relevance to the Russian epidemic. The strategy captures that expertise via technical assistance relationships, US NGO-to-Russian NGO partnerships, and government-to-government technical dialogue—all of which are intended to help catalyze a broader Russian response to the country's HIV/AIDS crisis.

Relationship of the Strategy to Other Donor Programs

This strategy was developed through consultation with major donors involved in HIV/AIDS activities in Russia. The strategy proposed herein takes into consideration these other donor activities—current and planned—and is structured to facilitate complementarities with those other programs. The emphasis in the strategy responds directly to the stage of the Russian epidemic and the necessity for aggressive prevention programs within the context of on-going responses. Policy dialogue elements of this strategy will be coordinated closely with the World Bank and DfID, both of which are committing substantial resources in this area. USAID will also ensure that the epidemiological and behavioral data developed under the USAID strategy are made available to these other donors to facilitate their policy development work with the Russian Government.

This strategy excludes support for anti-retroviral drug therapy to prevent mother-to-child transmission of HIV. The MOH has already developed its PMTCT protocols; CIDA has noted its own readiness to support elements of the program; and USAID resource

constraints effectively eliminate the option to provide ARVs to support the activity. Finally, USAID does not intend to support any technological interventions such as the use of auto-destruct syringes or condom quality testing, as these are not consistent with USAID's comparative advantages as a donor in Russia.

Geographic Coverage

In general. program activities will be focused in Moscow city, Saratov oblast and Samara oblast. Specific high transmission areas will be identified within these areas in order to more narrowly, and realistically, define the districts (in the case of Moscow) or cities (in the case of Saratov and Samara) where activities will be concentrated. Some activities, however, (such as media campaigns) will have more widespread coverage.

Depending on the availability of additional resources, USAID is also prepared to explore opportunities for the development of cooperative programs with other donors and through local NGO partnerships in different parts of the country where the epidemic is now emerging and where donor support is inadequate, for example in the Russian Far East and Siberia. These initiatives will be used to replicate lessons learned and to initiate innovative efforts in areas such as MTCT, care and support, and treatment. Alternatively, collaborations with other donors can provide an opportunity for USAID-supported interventions to complement the IDU-focused efforts of other donors.

Assumptions

- Adequate USG resources (financial, human) will be available to USAID/Russia to manage the program
- Russian Government resources for HIV/AIDS prevention programs will increase significantly (current estimated budget: $5-6million/year)
- The Russian Government's increasingly favorable attitude toward NGO participation in the national HIV/AIDS prevention program will continue, allowing for an expanded, substantive NGO role in that program over the next several years.
- Donor coordination and information sharing will improve
- USAID's restrictive policy with regard to harm reduction programs will not impede the efforts of USAID-funded NGOs to develop complementary programs with other donors prepared to support the HR elements of USAID-funded activities.

MONITORING AND EVALUATION PLAN

Under the Expanded Response Intensive Focus Country designation, USAID/Russia will be required to report on a number of HIV indicators. First, is the requirement that USAID/Russia report yearly the HIV seroprevalence levels for Russia. The second requirement for Intensive Focus countries is that they conduct a behavior change survey every 3-5 years. Additionally, Intensive Focus countries are required to report on indicators specific to the HIV strategies and programs that they manage. These requirements correspond with standard, recommended guidelines for comprehensive program evaluation - in short, measuring program impact, outcome, and output.

Impact Level - Reporting HIV seroprevalence

The Russian Ministry of Health currently screens more than 4 million blood donors and 2.5 million pregnant women annually for HIV. Although current WHO/UNAIDS recommendations call for the establishment of a system of sentinel surveillance to measure HIV in pregnant women at select sites, the Russian government appears committed to widespread screening, regardless of cost.

Although the required screening of all pregnant women was eliminated in 1995 (9 million pregnant women were tested in 1993-4, with 11 found to be positive), according to the Federal AIDS Center, this policy will soon be reinstated as part of government commitment to eliminate MTCT. Consequently, this data can be used to estimate trends in the HIV epidemic on a national scale.

Impact Indicator

- % of pregnant women with HIV infection

If possible, this data should be reported by age cohort and parity (emphasizing primagravid women aged 15-24 to improve comparability with international reporting).

Outcome Level - Measuring behavior change and strengthened networks

Outcome level evaluation emphasizes intermediate (3-5 year) program impacts towards the overall goals and objectives. For the 2002-5 Russia HIV/AIDS strategy, outcome level evaluation will focus upon measures of behavior change in key target populations, and evidence of strengthened networks and organizational capacity of partners. Indicators were chosen to reflect the overall, synergistic effect of the specific results framework previously presented. While monitoring indicators can be used to track outputs related to individual intermediate results, outcome indicators represent a measure of the sum total of activities.

Measuring key behavior change indicators

Behavior change is essential to averting a widespread HIV epidemic in Russia. Measuring the adoption of protective behaviors by populations at increased risk of HIV infection, and particularly those individuals with contact among both recognized high risk groups such as sex workers, IDUs, MSM as well as the general population (i.e. bridging populations), provides an effective way to monitor (and predict) trends in the overall epidemic over intermediate time frames.

Key behaviors will be measured using USAID/UNAIDS/UNGASS validated standard indicators measured through behavioral surveillance surveys (BSS) with IDU and FSW populations at the three focused sites of intervention. Specific indicators, which will be monitored, include:

Outcome Indicators – Behavior

- % condom use, last commercial sex among female sex workers

This figure will be reported among female sex worker populations at the three regions of USAID focus.

- % drug injectors using condoms at last sex with non-regular partners
- % drug injectors using condoms at last sex with commercial partners

This figure will be reported separately for male and female drug injectors reporting non-regular or commercial partners.

Measuring strengthened networks and increased capacity of partner organizations.

An important strategy for the Russia 2002-2005 HIV/AIDS strategy is the strengthening of NGO-GO and NGO-NGO networks to insure effective dissemination of lessons learned and best practices, and to improve overall coverage of prevention activities to marginalized and vulnerable populations.

While several donor agencies and institutions have developed various tools to assess organizational competence, there are no validated, standard indicators for strengthened networks or organizational development. Several important variables are understood, however, to be essential for this effort. These indicators will be self-assessed by partner NGOs and government organizations as a part of strategic and sustainability planning.

Outcome Indicators – Capacity Building

- % of NGO/GOs supported who provide training to NGOs/GOs/others within and outside of 3 targeted regions

This indicator will measure the extent to which the Russia HIV/AIDS strategy achieves its objectives to increase the capacity of NGO and GO partners to serve as technical resources, to improve the dissemination of best practices and lessons learned, and to strengthen local (Russian) NGO and GO networks throughout the country, and to expand coverage within the three selected intervention zones.

- % of NGOs supported with diversified funding sources

This indicator will measure the ability of funded NGOs to demonstrate their effectiveness to other donors, and to progress towards the development of a sustainable NGO sector in the response to HIV/AIDS epidemic.

An additional qualitative component to outcome-level evaluation proposed is a case study examining the policy impact of program activities. Specifically, during the final phase of program activities, a qualitative analysis of the effects of the development of model VCT and improved STI services, and the increased availability and use of behavioral data should be conducted to assess the success of these strategies.

Output Level - Measuring implementation and coverage

An important measure for the assessment of overall program impact is the level of coverage of USAID-supported program activities relative to the size of target populations within the specific geographic regions targeted for interventions. Specific indicators of coverage are currently under development by USAID/UNAIDS/UNGASS, however approximate measures of coverage can be calculated by applying estimates of population size versus outreach activities and services delivered[*]. To improve the sense of program benefit, and to increase the strategic approach of implementing partners, annual estimates of program coverage will be required by all USAID-supported implementing agencies (IAs). USAID will encourage these IAs to share experiences and lessons learned with other organizations working in overlapping sites, and to undertake collaborative strategic planning and population coverage estimations together with these other organizations.

Output Indicator – Coverage

- % of target populations reached

This indicator will measure the percentage of each targeted population (MSM, FSW, IDU) provided outreach and services, defined by sites of intervention.

Additionally, all funded activities under the proposed Intermediate Results will have specific monitoring indicators to assess the implementation and quality of activities. Examples of specific monitoring indicators are provided in the summary matrix of illustrative program activities, on page X.

[*] For example, coverage of programs working with IDU populations can be calculated by taking the estimated number of IDUs in a city and dividing by the number of individuals reached by program staff or outreach workers. This is likely to provide an imprecise estimate as there will be some double counting. However this can be reduced by restricting the time period to, for example, one month, which results in an estimate of the population reached *regularly*, rather than a measure of total population (ever) contacted. As the notion of 'coverage' implies that target populations have both accessibility and repeated use of program services (including information), measuring coverage over relatively short time spans (such as one month periods) is more appropriate than longer time periods. In addition, by calculating the measure on an on-going basis, program partners can monitor the increased coverage of their program or estimate an average level of coverage. USAID/Russia should contact USAID/W for further guidance and updates on recommended methods for calculating coverage.

Timetable for Monitoring and Evaluation Activities

Level	Key Indicators	Interval	Source
Impact	% of pregnant women with HIV infection	Annual	MOH
Outcome	% condom use, last commercial sex among female sex workers	2003, 2005	FSW BSS
	% drug injectors using condoms at last sex with non-regular partners	2003, 2005	IDU BSS
	% drug injectors using condoms at last sex with commercial partners	2003, 2005	IDU BSS
	% of NGO/GOs supported providing training to NGOs/GOs/others outside of 3 targeted regions	Annual	Self-assessment
	% of NGOs supported with diversified funding sources	Annual	Self-assessment
Monitoring	% coverage (by target population and site)	Annual	Self-assessment

MANAGEMENT PLAN

As with the 1998-2002 strategy, the strategy presented herein will continue to be implemented primarily with assistance from a number of cooperating agencies contracted by USAID/Washington and USAID/Russia. Key institutional participants in the strategy could include CDC, Population Services International, FHI/IMPACT and possibly Engender Health (formerly AVSC). The technical services of these agencies would be procured via Mission Field Support funding in the case of the CAs, and via a Participating Agency Service Agreement (PASA) or Inter-Agency Agreement (IAA) in the case of CDC.

The strategy itself should be shared as soon as possible with USAID/Russia's partners and stakeholders (including organizations representing people living with AIDS--PLWA), and should not be considered as a basis for program implementation until USAID/Russia has had benefit of its partners' feedback and suggestions. As the strategy does not envision any new, competitive procurement actions, broad distribution of the strategy (including via internet) should be appropriate. USAID/Russia should seek guidance on this issue from its regional procurement officer. Once partner and stakeholder feedback is in hand, USAID/Russia should develop a comprehensive implementation plan for the strategy, presumably with the participation of USAID backstop personnel from the relevant bureaus in USAID/Washington. This plan would be updated annually, again with the participation of the Mission's partners.

USAID/Russia management of the HIV/AIDS program would benefit from a formal team planning exercise designed to promote a more strategic vision of the overall program, and a more holistic approach to its management. The 1998-2002 strategy enabled USAID/Russia staff to manage the program essentially as CA managers (CDC, FHI,

PSI). The strategy presented herein involves significant linkages across these CA programs, and will require untried levels of coordination to ensure the overall success of the strategy. Moreover, in view of the increased management and program oversight requirements implicit in this strategy, USAID/Russia should consider the recruitment of an additional expatriate staff member to exercise day-to-day management responsibility for the Mission's HIV/AIDS program.

Finally, USAID/Russia will seek to maintain close communications with other donors, as well as between USAID's implementing agencies and implementing organizations supported by those other donors.

ANNEX I: ACHIEVEMENTS UNDER THE USAID/RUSSIA HIV/AIDS STRATEGY, 2000-2002

The following annex is an abbreviated version of the findings of the assessment/strategy team. Those interested in a more complete discussion of the accomplishments and constraints of HIV/AIDS program activities during the period 2000-2002 are referred to the separate report: "Overview of USAID/Russia HIV/AIDS Accomplishments 2000-2002: Report of the Synergy Assessment/Strategy Team." Key accomplishments and constraints, related to individual intermediate results are as follows:

IR 1: Improved service delivery capacity to reduce HIV/AIDS/STI transmission in selected vulnerable populations

IR 1.1: Improved STI management

1.1a: Optimize and disseminate STI management and counseling guidelines: Guidelines were distributed as planned. However, no assessment of STI management and counseling procedures outside of Moscow has been conducted since the guidelines were distributed. In 2001 the MOH/Skin & Dermatology Institute issued a directive to all affiliated (regional) laboratories setting forth selected elements of those guidelines. CDC reports that all labs in the MOH system are observing this directive.

1.1b: Improve laboratory, surveillance and research capacity: In 2001 the MOH also issued guidelines relating to laboratory testing procedures modeled on the 1998 CDC guidelines. Unlike the MOH directive relating to the diagnosis and treatment of congenital syphilis, these procedural guidelines did not establish mandatory practices, but allowed regional laboratories to implement them depending on the availability of financial and human resources at the local level.

1.1c: Collaborate on field-testing of new rapid, low-cost STI diagnostics: This component of the CDC program has never been pursued. One factor contributing to the Russian government's disinterest in the initiative may be the Russian Federal AIDS Center's own efforts (with support from Russian pharmaceutical companies) to develop rapid test kits locally.

1.1d: Demonstrate improved STI management that incorporates optimized treatment and counseling guidelines: USAID's original strategy states that CDC would "work with SANAM to update the national STI diagnosis and treatment guidelines and then train health providers to implement these reforms. These new guidelines would be field tested as one component of the model prevention program in several demonstration oblasts. IMPACT and PSI would implement these new guidelines at the oblast level in collaboration with CDC and SANAM". However, field testing and dissemination to the oblast level was not pursued.

1.1e: Increase collaboration with AIDS, Narcological and Women's Health Centers to promote referrals and comprehensive RH services: With the exception of some CDC-sponsored conferences, no work has proceeded on this sub-IR. As pointed out in the

Kirkland report, formidable obstacles exist to functional collaboration/integration among and between HIV, RH and narcology disciplines in Russia.

IR 1.2: Improved local capacity to design, implement and evaluate HIV/AIDS prevention programs

Two initiatives were undertaken in support of this IR, both managed by PSI: condom social marketing campaigns were conducted in Moscow, Samara and Saratov; and a Partnership Program (PP) provided training to several Russian NGOs who were linked with more experienced NGOs based in the US. PSI's condom social marketing campaign supported a generic campaign (entitled, 'Take it with you') in Moscow and a branded campaign ('Favorite') in Saratov and Samara. The program was not specifically targeted on high-risk, vulnerable youth, although it did provide information regarding the negative consequences of high-risk sexual behaviors. The PP has provided valuable training for several Russian NGOs, some of which are now poised to play a second-generation "mentoring" role themselves in support of other Russian NGOs. In Moscow, the Lower East Side Harm Reduction Center (LES) in New York City was partnered with No to Alcoholism and Drug Addiction (NAN); and Stonewall Recovery Services (SRS) of Seattle was partnered with the Russian NGO Accent. In Saratov, a consortium of Washington DC-based NGOs led by the Whitman Walker Clinic worked with a consortium of Saratov-based NGOs. Results of these partnerships to date are impressive. PSI data indicate that IDU visits to NAN/Moscow have increased significantly; Accent has increased its outreach to street-based sex workers; and sharing of needles and syringes has dropped markedly among IDU populations reached by Partner NGOs in Saratov. In Balakovo, Partnerships Program participant NAN is training another NGO (in Tomsk) about harm reduction, primary prevention, safe behavior and the importance of volunteers. An important aspect of both programs has been the development of stronger working relationships between NGOs, MoH AIDS Centers, and local leaders.

IR 1.3 Enhanced collaboration, resource, skills and information sharing

This component of the strategy was never pursued.

IR 2: Improved national HIV/AIDS/STI policy environment established through a more informed policy dialogue.

Boston University (BU) completed an analysis of various laws and regulations relevant to HIV/AIDS/STI and prepared several recommendations intended to address the shortcomings in these directives (See "Legal Issues in HIV/AIDS Prevention and Treatment in the Russian Federation" dated May 3, 2001). As part of its cooperative agreement with USAID/Russia the BU School of Public Health's Center for International Health also prepared a CD with a catalogue and archive of all related products from six years of cooperation for other policy makers and analysts. Independent policy analysis was provided on various aspects of health reform debates during the 1990s, including drafting assistance on regional and federal legislation and guidelines. Health expenditures surveys conducted by the program in 1998 and 1999 provided

groundbreaking information on the out-of-pocket payments for health care in Russia, which matched or exceeded public expenditures. While the contents of the CD are available on the web (with many documents in both Russian and English accessible at http://dcc2.bumc.bu.edu/RussianLegalHealthReform/), USAID/Russia is also using a wide network of channels to disseminate the CD to medical libraries throughout the NIS, USAID programs throughout the region, and a wide array of donors and Russian contacts. Meanwhile, several donors, including DfID, the World Bank and CIDA, plan to support policy development work with the Russian government under the terms of the various HIV/AIDS assistance strategies currently being prepared by these donors.

IR 3: Improve systems for collaboration and dissemination of information, resources and lessons learned.

3.0a: Support implementation of the UNAIDS Rapid Needs Assessment: As noted in the Kirkland *et al* report of March 2000, USAID was prepared to provide technical support to UNAIDS in this effort, but USAID was never contacted regarding possible collaboration. Aside from routine information sharing, USAID has not collaborated actively with UNAIDS on other ventures over the past two years.

3.0b: Strengthen AIDS Infoshare as a national center for HIV/AIDS information
3.0c: Disseminate information and lessons learned from demonstration oblast programs

The Kirkland *et al* report included an extensive discussion of USAID's efforts to strengthen AIDS Infoshare's capacity and performance as a source of HIV/AIDS information, and concluded that the organization was not prepared to undertake its intended assignment—not, at least, until the completion of an objective evaluation of its organization, strategy and readiness to perform as planned. The report also identified a significant gap between AIDS-Infoshare's own perception of its needs and the perception of its USAID-funded technical assistance organization, Family Health International (FHI/IMPACT). Given the two organizations' inability to bridge that gap, USAID/R is allowing the FHI assistance mechanism to lapse in 2002, and has no plans to renew any substantive relationship with AIDS Infoshare.

USAID has not attempted to establish another mechanism – i.e., to replace AIDS Infoshare – to facilitate broad dissemination of its program initiatives. Indeed, none of the other major donors active in the HIV/AIDS sector is Russia—virtually all of which support "demonstration" or pilot projects in selected regions of the country—seem to have developed a workable system to broadly share their projects' lessons learned and/or best practices.

ANNEX II: HIV & TUBERCULOSIS IN RUSSIA

Economic and social factors such as poverty and substance abuse, especially alcohol and intravenous drug use, along with dwindling resources for public health have contributed to the substantial increase in tuberculosis cases in Russia during the last decade. These same factors have also contributed to the spread of HIV infection. An estimated 26 million people in Russia or 1 in 6 individuals is infected with tuberculosis (Ref 1). As has been mentioned previously, the number of registered HIV cases currently approximates 180,000, though, this number is thought to be a gross underestimation. There is also thought to be a substantial overlap between populations with tuberculosis disease and infection and those at risk for HIV infection leading to an increase in the number of co infected individuals.

The yearly risk of developing active TB for people co infected with HIV is about 10% compared with a lifetime risk of 10% for HIV negative individuals (Ref 2). If spread of HIV is not prevented, co infection will accelerate the resurgence of TB. The potential for massive TB spread in HIV infected individuals in settings such as prisons, in which the rates of TB and multi-drug resistance TB (MDR-TB) are the highest, is especially alarming.

The system in Russia for diagnosing and treating tuberculosis is like the system for HIV/AIDS in that it is highly verticalized. Little active interaction has taken place to date between these two systems. Moreover, there has been significant resistance among the Russian TB system to reform its cost-ineffective hospital-based approach to the diagnosing and treatment of TB.

In addition to measures to limit HIV transmission, several other steps can be taken to further limit spread of HIV-related TB in Russia. These steps include widespread implementation of DOTS, the development of programs to successfully treat MDR-TB, and the treatment of latent TB infection in persons who are HIV positive. This last measure has been shown to be highly effective in preventing development of active TB in several settings (Ref 3).

HIV testing is done primarily in the government HIV centers while TB screening is done in TB clinics and dispensaries. What is primarily needed at this stage of the HIV epidemic and given the realities of the Russian medical system is a TB screening and referral mechanism done through the government and non-government HIV centers. In other words, there needs to be training within the HIV centers to perform a basic TB screening test and the establishment of a referral system to the TB clinics and dispensaries. Given the already well-established work by WHO and CDC in the three aforementioned oblasts, one or all of these three sites could serve as demonstration pilot projects.

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